

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

14552

3486

FILED MAY 3- 1952

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MO		c. LENGTH OF STAY (in this place) 25 years	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL (Middle)		d. STREET ADDRESS (If rural, give location) 236 Linden Ave.,	
3. NAME OF DECEASED (Type or Print) MARY FLETCHER MANLOVE		4. DATE OF DEATH (Month) (Day) (Year) 6 11 52	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 15, 1869
9. AGE (In years last birthday) 82		10. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Indianapolis, Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Stephen K. Keys.		13b. MOTHER'S MAIDEN NAME Mary Catherine Malott.	
14. NAME OF HUSBAND OR WIFE Horace T. Manlove.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Ruth T. Manlove; Clayton, Missouri	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH think 2wk 5yr	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular Fibrillation		DUE TO (b) Cerebral Vascular Accident	
DUE TO (c) Hypertension			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	
21f. HOW DID INJURY OCCUR? 33.1 X			
22. I hereby certify that I attended the deceased from 3-18-1952, to 4-11-1952, that I last saw the deceased alive on 4-11-1952, and that death occurred at 8:45p. m., from the causes and on the date stated above.			
23a. SIGNATURE Marvin Rosecrans M.D.		23b. ADDRESS BARNES HOSPITAL	
23c. DATE SIGNED 4-11-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE Apr. 13, 1952	
24c. NAME OF CEMETERY OR CREMATORY Crown Hill Cemetery		24d. LOCATION (City, town, or county) (State) Indianapolis, Indiana.	
DATE REC'D BY LOCAL REG. APR 15 1952		25. FUNERAL DIRECTOR'S SIGNATURE C.R. Lupton & Sons; 7233 Delmar Blvd.,	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Arnold W. Schoene

Licensed Embalmer No. *3864*

P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.